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# Exhibit B

**MINOR LEAGUE BASEBALL  
HEALTH AND WELFARE PLAN  
SUMMARY PLAN DESCRIPTION**

**Health, Vision, and Life Insurance Benefits for Minor League Players**

Effective as of January 1, 2016

DB1/ 83672741.3

CONFIDENTIAL

MLB0007449

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**Health and Welfare Plan Summary Plan Description****INTRODUCTION**

The Office of the Commissioner of Baseball (the “Office of the Commissioner”) has established the Minor League Baseball Health and Welfare Plan (the “Plan”) to enable the Major League Baseball Clubs to provide selected health and welfare benefits for certain of their eligible employees and their dependents. Eligible employees of the following Clubs are covered under the Plan for the purpose of providing health benefits, life insurance benefits, and vision benefits:

Angels Baseball LP	Los Angeles Dodgers, Inc.
Athletics Investment Group, LLC	Miami Marlins, L.P.
DBA Oakland Athletics Baseball Company	Milwaukee Brewers Baseball Club, L.P.
Atlanta National League Baseball Club, Inc.	Minnesota Twins, LLC
AZPB Limited Partnership	New York Yankees Partnership
Baltimore Orioles L.P.	Padres L.P.
The Baseball Club of Seattle, LLLP	The Phillies
The Boston Red Sox Baseball Club Limited Partnership	Pittsburgh Associates
Chicago Cubs Baseball Club, LLC	Rogers Blue Jays Baseball Partnership
Chicago White Sox, Ltd.	St. Louis Cardinals, LLC
The Cincinnati Reds, LLC	San Francisco Baseball Associates L.P.
Colorado Rockies Baseball Club, Ltd.	Sterling Mets, L.P.
Detroit Tigers, Inc.	Tampa Bay Rays Baseball, Ltd.
Houston Astros, LLC	Rangers Baseball, LLC
Kansas City Royals Baseball Corporation	Washington Nationals Baseball Club, LLC

One of the many requirements of the Employee Retirement Income Security Act of 1974 (“ERISA”), a federal law applying to employee benefit plans, is that employers must supply employees with a description of the various benefit plans it maintains. The information must be included in a summary plan description (“SPD”) for each plan. This document, together with the booklets and other descriptive materials you have received from the Office of the Commissioner, Highmark Blue Cross Blue Shield, Fort Dearborn Life Insurance Company, and Davis Vision, Inc. constitutes the SPD for the Plan with respect to Minor League Players.

Because benefits from the Plan will be of importance to you and your family, you should retain this SPD as a part of your permanent records, but be advised that it is only a summary. The SPD is shorter and less technical than the underlying legal documents that establish the Plan. The SPD also details who is eligible for benefits and specifies the nature of the health and welfare benefits. The SPD is not meant to alter the Plan or any legal instrument related to the Plan’s creation, operation, funding, or benefit payment obligations. **If there is any conflict or inconsistency between the SPD and the documents constituting the Plan, or with respect to any provision not discussed in the SPD, then the documents constituting the Plan will control.** You and your beneficiaries may examine the Plan, all amendments, and certain other documents and records pertaining to the Plan during regular business hours or by appointment at a mutually convenient time in the Plan Administrator’s office. You may obtain copies of the documents constituting the Plan and of certain reports from your Team Administrator (a reasonable charge may be imposed for those copies, as permitted by federal regulation).

**Health and Welfare Plan Summary Plan Description****ELIGIBILITY TO PARTICIPATE**

You are eligible to participate in the Plan if you are a full-time employee and you are classified as a Minor League Player signed under an approved Minor League Uniform Player Contract who is not covered by the Major League Baseball Players Benefit Plan or any health benefits plan sponsored by the Office of the Commissioner, a Club, or any other employer-sponsored plan. You are eligible to participate, as of the date you sign your contract with a participating Club.

*ACA Employer Mandate.* Your employer will establish appropriate initial and on-going measurement periods for purposes of determining which employees meet the definition of “full-time employee” as required by Code section 4980H. If your employer chooses to use a look-back measurement period, the look-back measurement period may vary in length by category of employee and may be changed prospectively from year to year at your employer’s discretion and to the extent permitted by 26 C.F.R. § 54.4980H-3. If an employee meets the definition of “full-time employee” during the applicable measurement period, as determined by your employer, the employee will be offered coverage for the duration of the next stability period that begins immediately following the measurement period and subject to any administrative period established by your employer. The length of the stability period and administrative period will comply with 26 C.F.R. § 54.4980H-3.

Notwithstanding the above, the following individuals are not eligible to participate in the Plan: (i) employees covered by a collective bargaining agreement unless the agreement provides for participation; (ii) any person performing services pursuant to an arrangement with a leasing organization, including but not limited to a “leased employee” within the meaning of section 414(n) of the Internal Revenue Code (“Code”); and (iii) independent contractors and other persons who are not treated by the Clubs as employees for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding.

In addition, if you are a Minor League Player and you are placed on one of the following lists, then you may be removed as an eligible employee at the sole discretion of the Club, if approved by the Office of the Commissioner:

- **Restricted List:** Includes a Minor League Player (i) who without permission from the Club, fails, within 10 days of the opening of the Club’s championship season, to report to or contract with the Club; (ii) who the Club deems will not be returning to active service, and (iii) whose placement is approved by the Office of the Commissioner.
- **Disqualified List:** Includes a Minor League Player (i) who violates a contract or reservation; (ii) who the Club deems will not be returning to active service, and (iii) whose placement is approved by the Office of the Commissioner.
- **Voluntarily Retired List:** Includes a Minor League Player (i) who desires to retire from the profession; (ii) who makes a written application to the Club and the Office of the Commissioner, stating fully the reason for retiring, and (iii) whose placement is approved by the Office of the Commissioner.

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- **Released:** Includes a Minor League Player (i) who a Club believes no longer has the ability to play at the professional level; and (ii) whose release is approved by the Office of the Commissioner.
- **Ineligible:** Includes a Minor League Player (i) who is found guilty of misconduct or other acts mentioned in Rule 21, or convicted of a crime involving moral turpitude; and (ii) whose placement is approved by the Office of the Commissioner.
- **Free Agent:** Includes a Minor League Player whose (i) contract term has expired and is now free to sign with any Club; and (ii) status as a Free Agent has been approved by the Office of the Commissioner.

**COVERAGE OF YOUR DEPENDENTS**

Coverage for health benefits is also extended to your spouse (in general, the person to whom you are legally married in accordance with the laws of the State or foreign jurisdiction where the marriage was licensed or performed); your legal child(ren) (for example, any biological children, adopted children, or children for whom you are the legal guardian), foster children, or step children under the age of 26; and your unmarried children who are dependent on you because of mental retardation or physical handicap. For a handicapped child to remain covered, you must submit proof of the child's inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child's attainment of the age 26. The proof must be in a form approved by your Club and must be resubmitted as required by your Club.

The Office of the Commissioner and/or your Club may in its sole discretion require proof of dependent status, including but not limited to affidavits attesting to dependent child status. Coverage for your dependents will begin on the same day as your coverage, provided you elect dependent coverage as explained in the section of this booklet entitled **ELECTIONS AND CONTRIBUTIONS** and supply any required proof of such individual's dependent status. Your spouse and dependent children are not eligible for life insurance benefits or vision benefits.

Please note, to the extent that an eligible child does not qualify as a tax dependent under section 152 of the Code (for example a child over the age of 18 who is not financially dependent on his or her parent), under some state tax laws, you will have taxable income equal to the value of the coverage. Although this income is not actually received by you in your paycheck, it is taxable to you and must be reported as income on your Form W-2.

**CESSATION OF PARTICIPATION**

Coverage for benefits under the Plan ends at midnight upon the first to occur of the following:

- the date you terminate employment with a Club;
- the date your Club ceases to participate in the Plan;
- the date all coverage or coverage for certain benefits is terminated for your particular employment classification, due to a modification of the Plan;

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- the last day of the last period for which any required contribution toward the cost of coverage was made;
- the date you cease to be eligible for all coverage or coverage for certain benefits, provided that:
  - for dependent children who attain age 26, coverage terminates on the first day of the month following the month in which they turn 26; and
  - for an employee who is otherwise ineligible under the Plan but was offered medical coverage solely on the basis of his or her “full-time employee” status under the ACA, coverage will terminate on the last day of the stability period for which the covered employee was determined to be a “full-time employee” under the ACA during a preceding measurement period (as determined by the Office of the Commissioner in accordance with 26 C.F.R. § 54.4980H-3);
- the date you cease to be an active employee for any reason, except for absences covered by vacation or sick leave; or
- the date the Plan terminates.

If you become unable to work due to a disability or you begin an approved leave of absence (in accordance with the personnel policies and practices of your Club), then your participation in the Plan may continue as follows:

- **Disabled Minor League Players:** If you are placed on the “Disabled List” because you sustained an injury that results in your not being physically able to play in a game, then your participation in the Plan will continue for the period during which you are on the Disabled List. If you are released from your Club, then your participation will terminate as of the date of release, but you may elect to continue your coverage with COBRA. Please see the section of this booklet entitled **CONTINUATION OF COVERAGE UNDER COBRA** for details.
- **Suspended Minor League Players:** If you are placed on the “Suspended List” because you have been suspended for insubordination or other misconduct, or for violation of any regulation or other provision of your contract, then your participation in the Plan will continue for the period during which you are on the Suspended List.
- **Temporarily Inactive List:** If you are placed on the temporarily inactive list (i) on account of a family member’s bona-fide illness, (ii) for absence excused for the performance of any personal obligation, or (iii) due to your not being in condition to render services as a result of absences described in (i) or (ii), then your participation in the Plan will continue for the period during which you are on the temporarily inactive list. However, if you are placed on a Restricted List, Disqualified List, Voluntary Retired List, are determined to be Ineligible, are released, or become a free agent, then your participation in the Plan will continue unless, and until, your Club removes you as an eligible employee and the Office of the Commissioner approves such removal.

Notwithstanding the above, the Plan Administrator may, in its sole discretion, terminate your, your spouse’s, or your dependent children’s coverage under the Plan to terminate if you, your spouse, or your dependent child(ren) provides false information or makes misrepresentations in connection with a claim for benefits; permits a non-participant to use a membership or

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other identification card for the purpose of wrongfully obtaining benefits; or obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or omissions. Please see the *Special Rules Relating to Rescissions of Coverage* subsection in the section of this booklet entitled **BENEFITS** for additional details.

Under certain circumstances, your coverage under the Plan may continue after the date coverage would otherwise end. Please see the section of this booklet entitled **CONTINUATION OF COVERAGE UNDER COBRA** for details. In addition, your Club may continue coverage during certain periods of absence, such as a leave of absence under the Family and Medical Leave Act of 1993 or a qualified military leave of absence as defined by the Uniform Services Employment and Reemployment Act of 1994, or disability in accordance with its written personnel policies and practices. Your Club may require contributions during periods of absence in accordance with its written personnel policies and practices.

**ELECTIONS AND CONTRIBUTIONS****Health Benefits**

Your Club pays the full cost of the premiums for health coverage for you. However, you must pay all or a portion of the premiums for health coverage for your eligible dependents. The materials you receive from your Club or Highmark Blue Cross Blue Shield prior to the beginning of each Plan Year will describe the premiums required for each coverage election.

Once your contract with a Club is signed and approved by the Office of the Commissioner, you are automatically enrolled in the health benefit for individual coverage effective as of the date you sign your contract, provided you are eligible for coverage (see the section entitled **ELIGIBILITY TO PARTICIPATE** in this booklet for details regarding eligibility). However, if you desire to add your spouse or eligible dependent children, then you must complete the necessary forms within 60 days of your eligibility for benefits. If you do not complete and return the necessary forms within 60 days of your initial eligibility, then you may only add coverage for your spouse and/or eligible dependent children with 12 months advance notice (unless you are eligible for a special enrollment period as discussed below). If you return the completed forms within the 60-day period, then coverage will be effective as of the date you sign your contract. You must notify the Plan of any subsequent change that would affect the coverage of your spouse and/or eligible dependent children.

Generally, you may only change your coverage elections with 12 months advance notice. However, if you are eligible for a special enrollment period, then you may join, re-join, or add dependents to your health coverage provided you notify the Plan within 60 days of the event triggering the special enrollment period. You are eligible for a special enrollment period if:

- you were covered under other health insurance coverage at the time you became eligible to enroll under the Plan, you stated in writing that you declined coverage in the Plan due to such other coverage, and you subsequently became ineligible for such other coverage;
- you added a dependent through marriage, birth, adoption, or placement for adoption; or

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- you and/or your dependent is covered under Medicaid or other State child health plan and that coverage is terminated due to loss of eligibility or you and/or your dependent becomes eligible for assistance under Medicaid or other State child health plan.

If you wish to change your health coverage elections during a special enrollment period, then you must notify the Plan within 60 days of the date of the event triggering the special enrollment period. Your election will be changed effective as of the date of such event. You must notify the Plan of any subsequent change that would affect the coverage of your spouse and/or eligible dependents.

**Life Insurance and Vision Benefits**

Coverage for life insurance and vision benefits is automatic once you become an eligible employee and will become effective as of the date you sign your contract. You do not need to complete any enrollment forms or pay any premiums. However, you must complete and return a beneficiary designation form for your life insurance benefits. Your spouse and dependent children are not eligible for life insurance and vision benefits.

**BENEFITS**

This section briefly summarizes the health and welfare benefits available under the Plan. For a more complete description of the benefits, please refer to the separate descriptive booklets that you have received from the Office of the Commissioner, Highmark Blue Cross Blue Shield, Fort Dearborn Life Insurance Company and Davis Vision, Inc.

*Special Note.* Benefits under the Plan are solely provided through a contract of insurance between the Office of the Commissioner and the insurers. The rights of each participant, dependent, beneficiary, or other person claiming through either of them to benefits under the Plan are defined and limited by the insurance policy that is in force at any particular time for the provisions of such benefits. A claimant may enforce rights under that policy directly against the insurer after exhausting administrative remedies in the section of this booklet entitled **CLAIMS PROCEDURE**. The Office of the Commissioner also retains the right, as policyholder, to take action in its discretion to enforce the policy of insurance on behalf of participants, dependents, and beneficiaries.

**Health Benefits**

Your health benefits will be provided through the Blue Cross and Blue Shield PPO (Preferred Provider Organization) Program underwritten by Highmark Blue Cross Blue Shield. This program generally provides 90% of all reasonable and customary physician and hospital costs for in-network covered expenses after you satisfy a \$250 individual and \$500 family deductible. The program covers 100% of all reasonable and customary costs for in-network routine preventative care services with no participant cost sharing. The program also provides 80% of all reasonable and customary physician and hospital costs for out-of-network expenses after you satisfy a \$500 individual and \$1,000 family deductible. There is an annual \$750 individual, and \$2,000 family out-of-pocket limit for in-network covered services, and an annual \$1,500 individual, and \$4,000 family out-of-pocket limit for out-of-network covered services. The out-of-pocket limit, under this benefit option, refers to the

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specified dollar amount of coinsurance and deductible you incur for covered services and covered medications. When you reach the out-of-pocket limit, the program begins to pay 100% of all covered expenses, with the exception of copayments and amounts in excess of the plan allowance. In addition, there is an annual \$6,350 individual and \$12,700 family total maximum out-of-pocket for in-network covered services. The total maximum out-of-pocket is the most you pay for in-network covered services during the policy year. When you or your covered family members reach this individual or family dollar amount, the program begins to pay 100% of all in-network covered expenses, including covered prescription drug expenses (described below), and no additional coinsurance, copayments or deductibles will be incurred for in-network covered services in that benefit period. There is no total maximum out-of-pocket for out-of-network benefits. The program also includes a prescription drug program that covers certain prescriptions. Prescriptions filled at an in-network pharmacy are generally discounted. After satisfying the annual in-network deductible described above, the program covers 90% of the cost of covered prescription drugs. Please refer to the benefits booklet for more information.

You are responsible for making decisions regarding the coverage option you choose and your selection of physicians and other medical providers. In addition, you and your physician are responsible for choosing the course of treatment for (or for choosing not to treat) any illness, injury or other medical condition. Neither the Office of the Commissioner nor your Club is in any way responsible for the outcome of any medical treatment of health care (or lack of such treatment or care). You should refer to the benefit booklet distributed to you to answer specific coverage questions and to help you decide which options are right for you and your family.

*Wellness Programs.* From time to time the Plan may offer wellness programs designed to promote the health and well being of all employees. These wellness programs may provide financial incentives to engage in activities that encourage healthy lifestyle changes, provide you with information about your current health condition by undergoing health screenings or answering questionnaires, give you the opportunity to receive health “coaching” and participate in disease management programs, provide on-line education tools, etc. These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and your employer money. Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communication. Any wellness program and related financial incentive offered under the Plan will comply with the requirements and limitations of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the ACA and related guidance.

*Special Rules Related to Lifetime and Annual Limits.* The Plan will not impose a lifetime or annual limit on the dollar value of Essential Health Benefits under any medical option available under the Plan. For this purpose, “Essential Health Benefits” are health-related items and services that fall into the following categories, as defined in section 1302 of the ACA, and further determined by the Secretary of Health and Human Services:

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- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

*Special Rules Related to Preexisting Condition Exclusions.* The Plan will not impose a preexisting condition exclusion under any medical option available under the Plan.

*Special Rules Related to Preventive Services.* Notwithstanding anything in this document to the contrary, in-network preventive health services will be covered at 100%. No cost-sharing (e.g., copayments, deductibles, or coinsurance) will apply for these in-network services. Preventive health services have been defined to include the following:

- Evidence-based items or services with an A or B rating recommended by the United States Preventative Services Task Force.
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Evidence-informed preventative care and screening provided for in the comprehensive guidelines support by the Health Resource and Services Administration (“HRSA”) for infants, children, and adolescents.
- Other evidence-informed preventative care and screening provided for in comprehensive guidelines supported by HRSA for women.

For more information contact the Plan Administrator or visit <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforAdults>.

*Special Rules Related to the Coverage of Clinical Trials.* The Plan will not deny a participant, covered spouse or dependent child the right to participate in an approved clinical trial for which such participant or covered spouse or dependent child is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A participant, covered spouse or dependent child participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms “qualified individual,” “life threatening disease or condition,” “approved clinical trial” and “routine patient costs” will have the same meaning as found in the Public Health

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Services Act section 2709.

*Special Cost Sharing Rules.* The Plan will comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the ACA, indexed annually. For purposes of this provision, cost-sharing includes deductibles, coinsurance, copayments or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Plan. Cost-sharing will not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan.

*Special Rules Related to Rescissions of Coverage.* The Plan will not cancel or discontinue coverage under a medical option with a retroactive effect with respect to a participant or covered spouse or dependent except in the event of fraud or intentional misrepresentation.

*Special Rules Related to Patient Protections.* With respect to any non-grandfathered medical benefit option provided under the Plan and to the extent applicable, the Plan will comply with the patient protections regarding choice of health care professionals and emergency care services under Public Health Services Act section 2719A and the regulations and guidance issued thereunder.

*Special Rules Related To Pregnancy And Childbirth.* The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, or require that a health care provider obtain authorization from the Plan or any insurance issuer for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

*Special Coverages Required By The Women's Health And Cancer Rights Act.* The Women's Health and Cancer Rights Act of 1998 requires the Plan to cover the following medical services in connection with coverage for a mastectomy:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance;
- prostheses; and
- physical complications in all stages of mastectomy, including lymphedemas.

These services will be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services is subject to applicable deductibles and coinsurance amounts.

*Special Rules Required by the Mental Health Parity and Addiction Equity Act.* The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations as required by Code section 9812 and ERISA section 712, and the regulations thereunder. Specifically:

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- The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.
- The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
- The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

*Medical Loss Ratio Rebates.* With respect to any insurance company rebates received by the Plan Sponsor that are subject to the Medical Loss Ratio (“MLR”) provisions of the ACA, the Plan Administrator will determine what portion (if any) of such rebate must be treated as “plan assets” under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of Participants; which Participants need not be the same Participants who made contributions under the policy that issued the rebate. Any portion of the rebate that is not treated as plan assets will be allocated among one or more of Participating Employer(s) as the Plan Sponsor in its sole discretion determines appropriate.

**Life Insurance Benefits**

If you are eligible to participate in the Plan, then you will automatically be provided with a \$50,000 life insurance benefit. The life insurance benefit is provided through Fort Dearborn Life Insurance Company.

**Vision Benefits**

If you are eligible to participate in the Plan, then you will automatically be provided with vision benefits. The vision benefits are provided through Davis Vision, Inc.

**CLAIMS PROCEDURE**

*If the booklets and other descriptive materials you have received from the Office of the Commissioner and insurance companies or other providers contain claims procedures, please refer to the claims procedures described therein. Otherwise, please refer to the claims procedure described herein.*

Benefits under the Plan are provided in accordance with contracts that the Plan has entered into with various insurance companies, and other providers or administrators of health and welfare benefits. Thus, claims for benefits may be made directly to the insurer, or other providers in the manner described in the booklets or other descriptive materials distributed by them. Upon request, the provider will advise a claimant of any benefits to which the

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claimant is entitled under the Plan. The health benefits provided through Highmark Blue Cross Blue Shield are subject to both internal and external claims review procedures required by health care reform. Please refer to the booklets and other descriptive materials you have received from the Office of the Commissioner, your Club and insurance companies for the Plan's internal and external claims procedures. These documents are furnished automatically, without charge, and as a separate document. In all other cases, if the claimant believes that the provider has failed to advise him or her of any benefit, then the claimant may file a written claim with the provider and that claim will be reviewed and a response made within a reasonable time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Health and Vision		
- Urgent Claims	72 hours	None
- Pre-Service Claims	30 days	15 days
- Post-Service Claims	60 days	15 days
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life Insurance	90 days	90 days

If the provider denies a particular claim for benefits in whole or in part, then it will provide the claimant with written notice setting forth the following:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- an explanation of the claim review procedure set forth below;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant has exhausted the appeals process;
- with respect to health and vision claims, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, then the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and
- with respect to health and vision claims, if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, then either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Within 180 days (60 days in the case of life insurance benefits) of receipt by a claimant of a notice denying a claim, the claimant or his or her duly authorized representative may request in writing a full and fair review of the claim by the insurer, or other provider in the manner described in the booklets and other descriptive material. The 180- or 60-day period may be extended where the nature of the benefit involved or other attendant circumstances make

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such extension appropriate. In connection with such review, the claimant or his or her duly authorized representative may review pertinent documents and may submit issues and comments in writing. The decision on review will be made promptly, and not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Health and Vision		
- Urgent Claims	72 hours	None
- Pre-Service Claims	30 days	None
- Post-Service Claims	60 days	None
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life Insurance	60 days	60 days

If the insurer denies a particular claim for benefits in whole or in part on review, then it will provide the claimant with written notice setting forth the following:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which the denial is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- a statement of the claimant's right to bring a civil action under section 502(a) of ERISA;
- with respect to health and vision benefits, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, then the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and
- with respect to health and vision benefits, if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, then either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the denial of a claim for health or vision benefits was based in whole or in part on a medical judgment, then a health care professional who was not consulted in connection with the denial that is the subject of the appeal, is not the subordinate of anyone who was consulted, and who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. In addition, the determination on appeal will not afford deference to the initial claim denial.

If the time limitations set forth above have not been exceeded, then no person may bring an action in a court of law unless the claims review procedure is exhausted and a final determination has been made. If the claimant or another interested party challenges the decision, then a review by a court of law will be limited to the facts, evidence, and issues

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presented during the claims review procedure described above. Facts and evidence that become known to the claimant or another interested person after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the initial appeal will be deemed waived. No person may bring an action in a court of law after one year from the date the final determination on the claim is made.

**CONTINUATION COVERAGE RIGHTS UNDER COBRA**

When your eligibility for coverage in the Plan ends, you may have the right to COBRA continuation coverage, which is a temporary extension of health coverage under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Office of the Commissioner.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

**COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of Plan health coverage (*i.e.*, health and vision) when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct.

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If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the plan as a "dependent child."

If the Office of the Commissioner or your Club provides retiree coverage under the Plan, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Office of the Commissioner, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Attn: Human Resources Department, Office of the Commissioner of Baseball, 245 Park Avenue, New York, NY 10167.**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified

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beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability Extension Of 18-Month Period Of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must notify the Plan Administrator of the disability within 60 days of the Social Security Administration determination and before the expiration of the 18-month period of continuation coverage. This notice must be sent to: Attn: Human Resources Department, Office of the Commissioner of Baseball, 245 Park Avenue, New York, NY 10167.**

**Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **You must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Attn: Human Resources Department, Office of the Commissioner of Baseball, 245 Park Avenue, New York, NY 10167.**

**Coverage You May Elect**

You may only elect to continue health and vision coverage if the coverage was in effect on the date of the qualifying event. Because life insurance is not a health care benefit protected by COBRA, you may not elect continuation coverage of life insurance benefits under the

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Plan. You may, however, have conversion rights under the applicable insurance policy.

**Other Coverage Options Besides COBRA Continuation Coverage**

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Office of the Commissioner's Human Resources Department. For more information about your rights under COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Keep Your Plan Informed Of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**California COBRA Participants**

Participants whose COBRA maximum coverage period would have been less than 36 months have an opportunity to extend their coverage under California state law upon the exhaustion of COBRA, but in no event to exceed 36 months from the date of the original COBRA qualifying event. For example, if a qualified beneficiary's COBRA coverage was effective on January 1, 2011, and the maximum coverage period would have extended COBRA for 18 months to July 1, 2013, the qualified beneficiary could extend coverage for an additional 18 months to up to a collective maximum coverage period of 36 months.

Those participants who will exhaust COBRA continuation coverage and have been on COBRA coverage for less than 36 months will receive a letter from the COBRA Administrator for the Plan to determine eligibility under the state continuation program. This request for additional coverage must be made no later than 30 calendar days prior to the end of your original COBRA expiration period (either 18th or 29th month).

The monthly rate of 110% of the conventional rates used for active employees will be applicable under state continuation. For participants deemed to be disabled as defined by the Social Security Administration, beginning with the 19th month, you will be charged a monthly rate of 150% of the conventional rates used for active employees.

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This additional continuation of coverage will only apply to California Employers and only participants residing or working in the State of California are eligible for this additional continuation under state continuation coverage.

**CONTINUATION OF COVERAGE DURING MILITARY SERVICE**

Employees and dependents who lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") may elect to continue coverage for up to 24 months. When the period of uniformed service is 31 or more days, any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

**PLAN ADMINISTRATOR**

The Plan Administrator is the Board of Trustees of the Minor League Baseball Trust. The name, business address, and business telephone number of the Board of Trustees are provided under the section below entitled **ADDITIONAL INFORMATION**.

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims. Notwithstanding the foregoing, benefits under the Plan will be paid only if the Plan Administrator (or its delegate) decides in its discretion that the applicant is entitled to them.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

**Health and Welfare Plan Summary Plan Description****PLAN AMENDMENT OR TERMINATION**

The Office of the Commissioner reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees and their dependents. Such changes may include, but are not limited to, the right to (i) change or eliminate benefits, (ii) increase or decrease employee contributions, (iii) increase or decrease deductibles and/or copayments, (iv) change the class(es) of employees and/or dependents covered by the Plan, and (v) change insurers, or other providers. The Office of the Commissioner may also make certain administrative changes to the Plan and amendments to the benefits provided under the Plan. The Office of the Commissioner also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination, or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination, or partial termination. There are no vested benefits under the Plan.

**ADDITIONAL INFORMATION**

**Plan Sponsor Information.** The Plan Sponsor is the Office of the Commissioner of Baseball. The address and telephone number as well as the employer identification number assigned to the Office of the Commissioner by the Internal Revenue Service are as follows:

*Address:* 245 Park Avenue  
New York, NY 10167  
*Telephone:* (212) 931-7800  
*Employer ID #:* **Redacted**

**Plan Administrator Information.** The Plan Administrator is the Board of Trustees of the Minor League Baseball Trust. The address and telephone number as well as the employer identification number assigned to the Board of Trustees by the Internal Revenue Service are as follows:

*Address:* c/o Office of the Commissioner of Baseball  
245 Park Avenue  
New York, NY 10167  
*Telephone:* (212) 931-7800  
*Employer ID #:* **Redacted**

**Plan Information.** The official Plan name, Plan identification number, and Plan Year (fiscal year used for plan records) for the Plan are as follows:

*Plan Name:* Minor League Baseball Health and Welfare Plan  
*Plan ID #:* 502  
*Plan Year:* Begins on January 1 and ends on December 31.

**Type of Plan.** The Plan is a welfare benefit plan providing the following types of benefits for Minor League Players: health benefits, vision benefits, and life insurance benefits.

**Claims Administration and Funding.** Claims for health benefits are paid and administered in accordance with an insurance contract the Plan has entered into with Highmark Blue Cross

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Blue Shield. Claims for life insurance benefits are paid and administered in accordance with an insurance contract the Plan has entered into with Fort Dearborn Life Insurance Company. Claims for vision benefits are paid and administered in accordance with an insurance contract the Plan has entered into with Davis Vision, Inc. Benefits are paid entirely by the insurance companies in accordance with the terms of the Plan and are guaranteed under the policies.

**Agent for Legal Process.** The agent for the service of legal process for the Plan is Steven Gonzalez at the address set forth above.

**SUBROGATION****General Principle**

When you or your enrolled spouse or dependent child(ren) receive benefits under the Plan that are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your spouse or your dependent child(ren) are required to reimburse the Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

**Specific Requirements and Plan Rights**

Because the Plan is entitled to reimbursement, the Plan will be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your spouse or dependent child(ren) may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your spouse or dependent child(ren) has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your spouse or dependent child(ren) to assert a claim to any of the benefits to which you or your spouse dependent child(ren) may be entitled. The Plan will not pay attorneys fees or costs associated with the claim or lawsuit without express written authorization from the Employer.

If the Plan should become aware that you or your spouse or dependent child(ren) has

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received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you, your spouse or any of your dependent child(ren) until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your spouse or dependent child(ren).

**Participant Duties and Actions**

By participating in the Plan you and your spouse or dependent child(ren) consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your spouse or dependent child(ren) agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your spouse or dependent child(ren) has any reason to believe that you or they may be entitled to recovery from any third party, you or your spouse or dependent child(ren) must notify the Plan. And, at that time, you and your spouse or dependent child(ren) (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your spouse or dependent child(ren) to any payment, amount or recovery from a third party.

If you or your spouse or dependent child(ren) fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you, your spouse and any of your dependent child(ren) until the agreement is signed. Alternatively, if you or your spouse or dependent child(ren) fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your spouse or dependent child(ren), you or your spouse or dependent child(ren)'s acceptance of such benefits will constitute agreement to the Plan's right to subrogation or reimbursement.

You and your spouse or dependent child(ren) consent and agree that you or they will not assign your or their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Employer.

**RECOUPMENT**

The Plan has the right to recover any mistaken payment, any overpayment, any payment that is made to any individual who was not eligible for that payment, or any payment that was required to have been made to the Plan under the **SUBROGATION** section above. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

**NO ASSIGNMENT OF BENEFITS**

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You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, will be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

**QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

A QMCSO is a court order giving a child who otherwise might not be eligible for medical coverage under the Plan a right to such coverage. Normally, such an order is issued by the court in connection with a divorce or separation. Before the Plan Administrator will comply with a QMCSO, it must determine that the court order meets the requirements of applicable law pertaining to QMCSOs. You will be notified if a court order relating to you is received by the Plan Administrator and the procedure used by the Plan Administrator to determine whether the order is a QMCSO. You may receive from the Plan Administrator, without charge, a copy of the Plan's QMCSO procedures.

**STATEMENT OF ERISA RIGHTS**

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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If your claim for a benefit is denied or ignored, in whole or in part, then you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**THIS IS INTENDED AS A SUMMARY OF THE PLAN DOCUMENT. IN THE EVENT OF ANY DISAGREEMENT BETWEEN THIS SUMMARY AND THE OFFICIAL PLAN DOCUMENT, AS IT MAY BE AMENDED FROM TIME TO TIME, THE PROVISIONS OF THE PLAN DOCUMENT WILL GOVERN. THE PLAN DOES NOT CONSTITUTE A CONTRACT OF EMPLOYMENT AND DOES NOT GIVE YOU THE RIGHT TO BE RETAINED IN THE EMPLOYMENT OF A CLUB.**